# THE WISCONSIN PARTNERSHIP PROGRAM
## An Integrated Care Model

## For People Who Are Elderly And
## For People with Physical Disabilities

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**TABLE OF CONTENTS**



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## EXECUTIVE SUMMARY

The Wisconsin Partnership Program, with funding support from The Robert Wood Johnson Foundation, has created a program that is home- and community-based, consumer-responsive, and quality-driven. It is a "Partnership Program" built from new partnership relationships between the individual consumers and their families, providers, the Wisconsin Department of Health and Family Services, the federal Health Care Financing Administration, participating Wisconsin counties, community-based organizations, the University of Wisconsin.

The primary motivation for creating the Partnership Program was to provide a more responsive health and long-term care system for Wisconsin – to provide both better access and higher quality services. The ultimate hope was that the integration of Medicare and Medicaid services would prove cost-effective by controlling expensive emergency, acute, and institutional care.

Integration itself is a dynamic concept. It means bringing together resources from a number of separate areas and developing a single whole that is in constant interaction and therefore becomes much more than the sum of its separate parts.

The Wisconsin Partnership Program found that the integration of acute, primary, and long-term care is best accomplished by means of a collaborative team approach. The collaboration is multi-faceted. The state collaborates with the federal Health Care Financing Administration (HCFA) and with non-profit, community-based organizations. The organizations collaborate with the state as purchaser and with health and long-term care providers who deliver the services. The providers collaborate with each other and with the consumer and the consumer's family.

Care management is team-based and fully collaborative. The prototype team is interdisciplinary and consists of a member, his/her physician, a registered nurse, a nurse practitioner and a social services coordinator or social worker. Other team members may be drawn in as the circumstances of a particular member's needs make it appropriate.

The Partnership Program began enrollment in 1995. As of June 31, 2000, 880 people were enrolled in the Partnership Program at four Wisconsin non-profit community organizations:

1. Elder Care of Dane County in Madison, Wisconsin, Dane County (enrolling adults age 55 and older);

2. Community Living Alliance in Madison, Wisconsin, Dane County (enrolling people with physical disabilities between the ages of 18 and 64);

3. Community Care for the Elderly in Milwaukee, Wisconsin, Milwaukee County (enrolling adults age 55 and older);

4. Community Health Partnership in Eau Claire, Wisconsin, Eau Claire, Dunn and Chippewa Counties (enrolling both older adults and people with physical disabilities).

The Wisconsin Partnership Program began operations as a partially capitated Medicaid pre-paid health plan in December 1995. In January 1999, the program converted to a fully-capitated, dual Medicaid and Medicare (1115/222) waiver that combines Medicaid and Medicare funds into one funding stream.

The collaborative, interdisciplinary version of an integrated care model has proven to be a successful route to achieving the major goals articulated as the ideals of the program. It has resulted in an increase in people's ability to live in the community and participate in decisions about their own health care, and has improved the quality of health care and service delivery while containing costs.

This document is divided into two parts. The first part offers a brief overview of the program, the social, political, and Department context in which it developed, stories of four participants designed to convey the general tenor of the program, and general program features. Part I also outlines lessons learned by the Department and Partnership organizations as they developed and implemented the program.

Part II presents an action plan from the perspective of the Department and of the community-based organizations – things to consider when implementing such a program.

The monograph is supplemented with appendices with detailed information on the interdisciplinary team model, the dual waiver checklist, physician panel development, financial management issues, and processing complaints, grievances and appeals.

## INTRODUCTION

The purpose of this document is to capture the experience of the Wisconsin Partnership Program in order to assist others in creating their own program. Technically speaking, the Wisconsin Partnership Program is a capitated, Medicare/Medicaid system of health and long-term care for people who are elderly and people with physical disabilities. It is based on an integrated model made operational by collaborative interdisciplinary teams. But to understand the key element in the Partnership Program's success, it is crucial to get a feel for the level of intensity and excitement that energized both the vision and the painstaking fulfillment of the vision as it was made operational in actual every day service to participants.

Try to put yourself in the place of the people who helped build the Wisconsin Partnership Program. Imagine the moment when they were searching for models to bridge the gap between vision and reality. This will help you understand how heavily the creation of this successful new program leaned on both the energy of hope and the "can do" confidence to act on hope.

The actual time when the vision first took wing was around 1988. Nationally, a growing population of elderly people and people with physical disabilities were expressing the wish to remain in their own home. The entire health care industry had begun to engage in extensive change and multiple paradigm shifts – from a health care system dependent on post-event treatment to a system that emphasizes prevention, from fee-for-service to managed care, and from top-down management systems to collaborative-based systems.

In Wisconsin, people wanted to create a program to put consumers at the center of a health care system that filled their medical, psychosocial and everyday needs. They wanted a program that would provide high quality service as well as a way for consumers to stay in their home rather than resign their fate to institutional care. The time was – and still is – right for such a vision.

Times of change invite innovation and creativity.

The process of change involves moving from the conception of an ideal … to a model of the ideal … to the real thing in operation, which in this case means a real team attending to a person in need of care. Getting the vision is the exciting and immediately rewarding

part of the process. Creating the model and putting it to work is the hardest most pedestrian part. In the chaotic moment when all change is possible, imagine what it is like to find balance as the earth moves under your feet. Imagine the excitement and satisfaction of those people in Wisconsin who watched the vision come to life and who now participate every day in making hope come true.

It is important to take into account the energy that comes from making a good idea work because that energy will be needed. As Thomas E. Hamilton (one of the pioneers in the creation of the Wisconsin Partnership Program) advises, "Keep a clear focus on the deeper vision, the values of choice and good quality care, values that speak to the desires of people who need care, the general population, and the care givers. It will energize you to get through the detail and drudgery involved in making large-scale change work."

The Wisconsin Partnership Program has successfully demonstrated that integrating acute and long-term care is feasible, can be implemented by community-based organizations, and works for multiple age and target groups in various geographic settings, urban and rural. Members currently represent the full range of American cultural diversity, including émigrés from Russia, Cambodia, China, Mexico, South America, and the Indian subcontinent, live in urban and rural settings, range in age from 19 to 100, and have a wide range of disabilities.

What follows in Part I of this document is a brief history, a few success stories to help give substance to what has been so rewarding in the program's success, a description of the program's features and the lessons learned to date. Part II offers a basic description of actions necessary to implement a Partnership Program. The actions suggested are, of course, based on the Wisconsin experience.

Specific details may differ from state to state because of differing state laws and regulations, practices and protocols. However, we're hopeful that the structure of tasks will be applicable and helpful for most states. For example, the details of reconciling Medicaid and Medicare and securing the necessary waiver will vary state by state. However, the need to accomplish these tasks will be relatively constant, and the Wisconsin experience should be helpful in understanding the necessary steps for pursuing the process.

In the spirit of sharing, those who experienced the challenges and celebrated the successes in Wisconsin sincerely hope this document makes the pursuit of success easier

than it could be. After all, the second traveler on any journey always has the advantage of a slightly more beaten path.

**Acknowledgements**

The Wisconsin Partnership Program is indebted to its many collaborators, including the Robert Wood Johnson Foundation, the federal Health Care Financing Administration, Wisconsin Department of Health and Family Services, University of Wisconsin-Madison, the four Partnership organizations (Elder Care of Dane County, Community Living Alliance, Community Care for the Elderly, Community Health Partnership), and the participating counties (Dane, Milwaukee, Eau Claire, Dunn and Chippewa). The program is also indebted to Partners for Community Service, Inc. for its many services to the Partnership organizations.

Within the Wisconsin Department of Health and Family Services, the Center for Delivery Systems Development, the Division of Health Care Financing, and units of the Division of Supportive Living have played important roles. Additional collaborators who assisted in making the Wisconsin Partnership Program successfully consumer responsive include the Wisconsin Coalition of Advocacy and the Independent Living Centers.

Finally, the Wisconsin Partnership Program is indebted to the values articulated in Wisconsin's extensive history of providing community-based care.

# PART I

## THE WISCONSIN PARTNERSHIP PROGRAM

### A BRIEF DEFINITION

The Wisconsin Partnership Program, with funding support from The Robert Wood Johnson Foundation, has created a model of care that integrates health and long-term care services for people who are elderly and people with disabilities.

The purpose of the program is to provide high-quality, consumer-centered, comprehensive and continuous care across settings and providers. To achieve this goal, the program integrates Medicaid and Medicare and uses a model of service delivery based on collaborative, interdisciplinary teams. In practice, each Partnership organization has multiple teams.

Since 1994, Partnership has been implemented at four community-based organizations in Wisconsin. Members have been enrolling since 1995.

As of June 31, 2000, 880 people were enrolled in the Partnership Program at four Wisconsin organizations:

1. Elder Care of Dane County in Madison, Wisconsin, Dane County (enrolling adults age 55 and older);

2. Community Living Alliance in Madison, Wisconsin, Dane County (enrolling people with physical disabilities between the ages of 18 and 65);

3. Community Care for the Elderly in Milwaukee, Wisconsin, Milwaukee County (enrolling adults age 55 and older);

4. Community Health Partnership in Eau Claire, Wisconsin, Eau Claire, Dunn and Chippewa Counties (enrolling both older adults and people with physical disabilities).

## CONTEXTUAL BACKGROUND

The Wisconsin Partnership Program began with a few people driven by a strong desire to create and implement a program that does what the excellent Program for the All Inclusive Care of the Elderly (PACE) model does, but with a few significant changes to make the program more attractive to consumers. Founders of the Partnership Program wanted to change the organization of service delivery from a day care center to the participant's home. They wanted to let the participant keep his or her primary physician rather than having to change to an assigned physician just at the point when the participant least wants to make a change. And they wanted to serve people with disabilities as well as the elderly.

Founding Principal Investigator Thomas E. Hamilton (now the Director of the Elderly & Disabled Health Program Group for the federal Health Care Finance Administration) recalls a defining moment at the National PACE conference in 1988 where he was the keynote speaker. He was impressed with PACE's model for service delivery and replication, and was already engaged with others on "the germ of an idea" for changes to the PACE model. Tom later went with others to San Francisco to study the PACE model. After his visit, he immediately engaged in long conversations, planning how to develop a model that solved problems of integrating health and long-term care.

There were many people involved with the ideas at this point. By good fortune, as Tom explains it, the Robert Wood Johnson Foundation had a solicitation out just as the ideas began to take shape. In December 1992, the concept was presented to the Foundation and a grant to develop the concept was secured.

At the time of this initial undertaking, PACE was the only integrated model; there was little home health care and managed care was just getting started. With an initial grant to develop the ideas, the people from the Department of Health and Family Services began pulling in groups and drawing on Wisconsin's Independent Living Centers for information to help feed the search for a new model.

The Robert Wood Foundation responded to the initial concept development and provided substantial funding from 1994 through 1999 to assist in the development of the model and in the development of the actual Wisconsin Partnership Program. The program development was served by the continuity of Wisconsin's Governor Tommy Thompson's administration. Thompson has been in office from 1987 to the present. Thompson's Secretary of Health and Family Services, Joe Leean, has consistently enthusiastically endorsed the program.

The initial question for the state was how it could assist in the development of a new model without playing an entirely regulatory role – a partnership rather than a purchasing model.

## Defining the Model

Before arriving at a satisfactory model, founders of the Wisconsin Partnership Program considered several alternatives. Team models that divide decision-making and/or accountability, or that allow the shifting of costs and/or accountability were considered and rejected. The models considered included:

1. *Case load by discipline*
   In this model, individuals are served by long-term care or health care based on assumptions about where the individual's greatest need is likely to be. This model was rejected because experience indicated that increasing needs in one of these areas frequently corresponds to increasing needs in the other.

2. *Case load by setting (referrals)*
   In this model long term support is primarily the domain of social work, while institutional and "skilled" (home care) is commonly the domain of nursing. In cases where the lead role switches as the patient moves from one system to the next, accountability can fall between the cracks.

3. *Shared case load/Parallel work*
   This multidisciplinary model brings disciplines to the table after they have formulated separate plans for addressing problems. This model, although widely used in health care settings, perpetuates a division of labor by discipline rather than true collaboration.

4. *The compromise model*
   In this model the available funds are divided equally between health care and long-term care services so that neither group uses more than a predetermined "fair share" of the total resources. Team members work in separate offices and are accountable for separate domains of service. The arrangement might encourage the appearance of collaboration while maintaining separation. It could easily result in shifting accountability for both cost and quality while care and services continue to be fragmented.

The Wisconsin Partnership Program ultimately settled on a precise model of team-based care management. The model is based on the use of collaborative interdisciplinary teams. It is a model that best accomplishes the stated project goals and presents a coherent approach to decision-making and accountability.

**A Note on Terminology:** The Wisconsin Partnership Program distinguishes "multidisciplinary" from "interdisciplinary." Multidisciplinary means bringing several disciplines to bear on an issue or problem, but the experts from each discipline do not necessarily collaborate. Interdisciplinary means experts from several disciplines interact to arrive at a course of action in response to an issue or problem.

The Wisconsin Partnership Program was originally designed as two models of an integrated care program – one for the elderly and one for people with disabilities. In practice, the separation of the two groups proved to be largely unnecessary. In fact, one of Wisconsin's Partnership organizations operates the program from the same model for both target groups.

The Wisconsin Partnership Program was first implemented as a partially capitated Medicaid pre-paid health plan in December 1995. In January 1999, the Program began operating under a fully-capitated, dual Medicaid and Medicare (1115/222) waiver that combined Medicaid and Medicare funds into one funding stream.

Although the Partnership Program was developed through the assistance of the Robert Wood Johnson Foundation, it has become a self-sustaining system. State staff members who were originally funded by RWJF are now fully funded by the State of Wisconsin. The individual Partnership organizations are operating independent of state assistance and are fully operational under the dual (1115/222) waiver.

Within the Department of Health and Family Services, the Wisconsin Partnership Program has moved away from regulation of structure and process and toward outcomes contracting. The move is part of the process the State of Wisconsin has undertaken to rethink the way government approaches quality, in terms of measures, monitoring, staffing and organizational responsibilities.

## SUCCESS STORIES

### A Promising Beginning

After a site visit to the foud Wisconsin Partnership organizations, James W. Hawthorne, Project Officer from the Health Care Financing Administration (HCFA) had this to say in a March 2, 2000 letter. "We concluded our visit quite convinced that the care delivery model that is being developed at these organizations has the potential to become a national model for delivering services to the frail elderly and to people with disabilities. After visiting and speaking with numerous participants it was clear to us that the program is making a tremendous difference in both the quality of the care they are receiving and in the quality of their lives."

### A Representative Story From Each Partnership Organization

The following stories are given in some detail primarily to communicate the complexity and comprehensiveness of services provided in the Wisconsin Partnership Program as well as the members' appreciation.

*Community Living Alliance – Member Story*
The member is a 42-year old married female with ALS, asthma, irritable bowel syndrome, and a hx. of seizure disorder. At the time of her enrollment with the Wisconsin Partnership Program in 1997, the member was living in a nursing home due to increased loss of functioning following a pulmonary embolism. Although she and her spouse were very loving and close, having grown up together all their lives, he was experiencing his own health problems related to caregiver stress. Neither person had supportive extended family to help out. While the spouse was eager to have his wife at home, and although she frequently said she wanted to leave the nursing home, he was unable to manage the extensive care she would require without assistance.

When the member was ready to enroll in Wisconsin Partnership Program, plans were made to bring her home. The Partnership provided adaptive equipment and significant daily living assistance from attendants. This assistance relieved some of the caregiver stress on the member's spouse, and enabled him to continue his employment outside the home. When the family decided to move into a more accessible apartment last year, the team social worker was available to assist with locating housing.

Since this family has been involved with Wisconsin Partnership Program, the member's health has been stabilized. ER use has been significantly reduced. Before enrolling in the Partnership, the member and spouse used the ER for events which did not warrant emergency or hospital admission, but they felt this was their only source of reassurance when changes arose in the member's health. After working to build a close relationship with this family, they now check in frequently with the Partnership team, and the issues which would have led to an ER visit in the past are handled in a less intrusive and stressful manner in the home.

In addition, the spouse has experienced a reduction in anxiety that comes from knowing he can also depend upon Wisconsin Partnership Program for support. He often calls various team members for support. The Partnership team social worker assisted him with a referral for counseling for caregiver stress, and after some advocacy, this service is being paid for by his employer's insurance. Finally, religion plays an extremely important role in this family's life, and the Wisconsin Partnership Program staff have worked with the church and other agencies as needed to provide a holistic approach to this care.

ALS is a terminal illness, and it is this family's wish that the member live at home until the end of her illness. When the time comes, the Wisconsin Partnership Program will assist the family with exploring options for hospice care and will support the family in fulfilling their wishes during that time as well.

*Community Care for the Elderly - Member Story*
Mr. & Mrs. Frister are 77 and 72 years old, respectively, have been married for 43 years, have no children, and reside in a City of Milwaukee Housing Authority subsidized housing unit. Before retirement Mr. Frister was a truck driver and Mrs. Frister was employed by Goodwill Industries.

Richard & Rita Frister enrolled in CCE Partnership North on April 7, 1999. They were referred to the program by a nursing home social worker through SET Ministry. SET Ministry is a social service agency located in the public housing unit where the Fristers reside. Mr. Frister was in a nursing home recovering from pneumonia. The social worker believed the couple was at risk because Mr. Frister has limited use of his left arm and leg, from a previous stroke, and Mrs. Frister was wheel chair bound. The social worker believed Mr. Frister was tired out from being the primary care giver for his wife. Mr. Frister did all of the homemaking chores including cleaning, cooking, health monitoring, laundry and money management. The social worker had reason to believe that the Frister's were being taken advantage of financially by some of the buildings other residents. Mr. Frister is loquacious and outgoing, and does most of the talking for the couple. Mrs. Frister has a hearing impairment but did contribute to the interview. The couple had also experienced a number of falls.

Upon enrollment in CCE Partnership, the Frister's were assessed and the following interventions were made:

- Mrs. Frister received a new walker with swivel wheels, a pair of orthopedic shoes and physical therapy for 3-4 months. She was put on a home exercise program. These interventions stopped her frequent falls. She no longer uses the wheel chair. Mrs. Frister is seen at the CCE Day Center two times per week for blood sugar monitoring and her other health needs.

- Mr. Frister was outfitted with new orthopedic shoes and a lower extremity brace to assist his ambulation. He receives OT/PT that he said has helped him

quite a bit and he has "learned a lot" from the CCE staff. He feels the therapy has also helped his wife's balance.

- The Fristers are bathed at the day center. They attend CCE two days per week and Village Church Adult Day Center two days per week. Mr. Frister feels this keeps them active and they enjoy that.

Housekeeping, transportation to medical appointments and laundry service are in place for the Fristers. This gives Mr. Frister relief from the daily chores. He does their money management and said it is nice with "no medical bills; the only expense is food and now we have enough of that." A Partnership nurse visits their residence one time per week.

Because Mr. Frister is the primary care giver for his wife and has his own health and physical limitations, CCE Partnership is instrumental in keeping them at home and in their community. Mr. Frister stated "We like CCE because the medications, nurses, therapy ...you have it all in one place." His closing comment was, "We like it here, we like the people here."

*Community Health Partnership - Member Story*
Frances "Mae" O'Donnell enrolled in Community Health Partnership, Inc. on January 7, 1999. She is 78 years old and lives alone in her own apartment in Menomonee. When she enrolled in the program she had just had heart surgery in December, 1998, was on oxygen and insulin dependent. Mae's extended family was, and continues to be, very involved and supportive. At the time of her enrollment she was feeling like family had "done enough" to help support her. She was looking for another resource to lighten the load on them. Mae reports she has always been very independent. Prior to surgery she was doing all of her own cooking, cleaning and driving.

During the enrollment process she expressed her concern about "difficulty paying for medications". She often had to choose between purchasing her medications or meeting other needs such as groceries and paying bills. Mae was also frustrated about being so "weak" after surgery and not able to do everything for herself anymore. In-home services, such as medication/insulin delivery/set-up, diabetic monitoring, home respiratory services (oxygen/nebulizer), and housecleaning are currently provided to Mae.

Over the past year Mae's recovery has been steady. At times she is now able to drive herself and she does all of her own cooking and grocery shopping. Initially Mae's CHP "team" was quite involved in her life. Currently the "team" is a "safety net" and she now finds comfort in knowing we're "just a phone call away". When asked "what the program has done for you," she explains she is thankful for the "medical" care and the different pieces of equipment such as a bath bench and a bed wedge; but more importantly she says, "it's the way we make her feel special". She appreciated our visit and the plant we gave her on her birthday and she "looks forward to our visits"!

*Elder Care of Dane County – Member Story*

Bob enrolled in Elder Care Partnership in March of 1998, when he was 63 years old. At the time of enrollment, Bob had familial limb-girdle muscular dystrophy, chronic respiratory failure, ASHD/hypertension, sleep apnea, urinary incontinence, depression and difficulty swallowing. (His muscular dystrophy disease typically results in weakness and wasting, affecting the shoulder girdle and pelvic girdle first. The disease progresses slowly, with death most commonly occurring as a consequence of cardiopulmonary complications.) Bob is confined to a wheelchair due to his muscular dystrophy. He was taking 12 scheduled medications daily.

Bob lives with his wife Arlene in Marshall. She is his primary care giver and a supportive partner. Because of Elder Care's involvement, Arlene was able to retire from her job in January of 1999. She and Robert are very happy to have more time together. Independence is very important to Bob. One of his biggest concerns on enrollment was being able to get around town in his power wheelchair. This had been difficult for him in the past because of the way the garage was set up, and the size of his van. In 1999, Elder Care helped pay for the remodeling of their carport to allow him to enter and exit his van in his wheelchair while under the shelter of the carport. Modifications were made to the van to make it more accessible. As a result, Bob is able to be out in the community without his wife even if the weather is bad. Elder Care also paid for the remodeling of his shower to accommodate his decreased functional status.

Bob receives regular health maintenance and monitoring from the Team NP and RN, for his incontinence, respiratory problems, difficulty swallowing, hypertension, muscular dystrophy, and sleep apnea. Bob's team Social Worker provides supportive counseling for his depression, and also support to his wife Arlene. To decrease the risk of injury due to falls, lifeline was initiated and a PT/OT home evaluation was completed.

## PROGRAM FEATURES

Members of the Wisconsin Partnership Program receive home and community-based services, physician services, and all other medical care delivered in the member's home or a setting of his/her choice.

- Members, ideally, may keep their previous physician.

- Care management is team-based and fully collaborative.
  - ✓ The prototype team is interdisciplinary and consists of a member, his/her physician, a registered nurse, a nurse practitioner and a social services coordinator or social worker. Other team members may be drawn in as the circumstances of a particular member's needs make it appropriate.

  - ✓ The team collaborates on the development of a care plan and coordinates all service delivery.

  - ✓ The team as a unit is responsible and accountable for decisions about how expenditures are made and outcomes achieved.

  - ✓ Resources are assessed by the team, rather than by discipline.

  - ✓ Nurses and social workers are co-located in order to maximize opportunities for interactions between the disciplines.

| KEY ELEMENT:<br>The participating member or consumer is the central figure on the team and his/her desires and expectations figure prominently in the overall care plan as well as in individual solutions to specific care issues. |
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### Services are Provided by Community-Based Organizations

Participating organizations are chosen through the "request for proposal" process. These organizations enter into Medicaid managed care contracts with both the Wisconsin Department of Health and Family Services and the federal Health Care Finance Administration (HCFA).

- Under these contracts, the participating organizations receive monthly capitation payments for each member.

- Members' long-term care and acute health care, including physician services, are paid out of the capitation payment.

- Contractors are responsible for the care of each person regardless of provider or service setting – whether it's home, hospital, or nursing home, etc.

## Eligibility Requirements

Participation in the Wisconsin Partnership Program is voluntary. To be a member, individuals must be either age 65 or older, age 55 or older with a disability determination, or age 18-55 with a disability determination. They must be eligible for Medicaid and meet the Wisconsin Medicaid nursing home level of care requirement. People who are eligible for Medicaid alone and people who are eligible for both Medicaid and Medicare can qualify to be members.

## Program Goals

- Improve the quality of health care and service delivery while containing costs.
- Reduce fragmentation and inefficiency in the existing health care delivery system.
- Increase people's ability to live in the community and to participate in decisions about their own health care.

## Enrollment

Enrollment in the Partnership Program is voluntary. Participants may disenroll at any time. The Partnership contractor is prohibited from involuntarily disenrolling a participant except under exceptional conditions acceptable to the Department. In the history of the program, only one (1) participant has been "involuntarily disenrolled" by a Partnership organization, and this was due to the participant's loss of Medicaid eligibility.

## RELATIONSHIP OF WISCONSIN PARTNERSHIP PROGRAM TO OTHER WISCONSIN MEDICAID PROGRAMS

### Wisconsin Partnership Program and the Community Options Program (COP)

The Wisconsin Partnership Program builds on the legacy of Wisconsin's highly acclaimed Community Options Program. COP is a fee-for-service (rather than managed care) program that operates under 1915(c) authority. It provides the following community-based services to persons who are at risk of entering a nursing home: case planning, care management, and daily living skills training – plus any services, equipment or adaptive aids a person needs to remain safely in the community. Because of a lengthy waiting list, COP case managers frequently sends referrals to the Wisconsin Partnership Program.

### Wisconsin Partnership Program and PACE

In many respects the Wisconsin Partnership Program resembles PACE – the only other managed care program in the country that fully integrates health and long term care. However, the differences are significant.

- Services in the Wisconsin Partnership Program are primarily home-based and do not rely on a day center as a structure in which to provide services.

- Wisconsin Partnership Program serves individuals with significant physical disabilities as well as people who are elderly, while PACE serves only the elderly population.

- Wisconsin Partnership Program shifts the focus from provider to consumer.

- PACE primary care physicians are employed by the PACE site. Wisconsin Partnership Program supports consumers' desire to maintain the relationship they already have with their physician.

- A Wisconsin Partnership Program goal is to collect data to establish performance benchmarks for community-based long-term care. Very little is known about what constitutes good performance in health or long-term care for frail elderly populations. PACE tracks some information within the context of the PACE model. Wisconsin's other Home and Community Based Waiver Programs manage long-term care, but are not responsible for participant health services. Managed health care organizations track health variables, but blend statistics for well and ill populations. Wisconsin Partnership Program has an advantage – it has access to a shared Medicaid-Medicare database which allows for study and analysis of both health and long-term care data for Wisconsin and Partnership participants.

**Additional Wisconsin Medicaid Managed Care Programs**

The Wisconsin Partnership Program was developed within the context of Wisconsin's exceptional track record in the design and management of Medicaid managed care programs, innovative demonstrations, and long-term care waiver programs. The Wisconsin Department of Health and Family Services is the State Medicaid Agency, and health and long-term care represent over 80 percent of the Department's responsibility. The following brief summaries are designed to show the number and kinds of clients served through Wisconsin Medicaid managed care, the kinds of contracts and quality measures in place, and plans for program expansions.

- **Family Care.** Family Care is a new, long-term, managed care demonstration project initiated in 1999 for the elderly and people with disabilities in Wisconsin. Family Care is a melding of a 1915 (c), and 1915 (b) waiver, and a pre-paid health plan contract. It pulls together all the long-term care services in Wisconsin, exclusive of acute and primary care and, using capitated rates, delivers them through a county-based care management organization. Family Care has heralded the development of many new tools and methodologies, including quality outcome measures, some of which are based on the Partnership Program experience. As of September 2000, four (4) demonstration counties were providing services, with a total enrollment of 1,513. The decision regarding statewide expansion of Family Care will be considered during the 2003-05 Wisconsin Legislative session.

- **The Independent Care Program (I-Care).** Initiated in 1994 under a research and demonstration grant from HCFA, I-Care was the first Wisconsin Medicaid risk-based program for "high-cost" populations. I-Care coordinates medical and social services for 4,000 SSI disabled Medicaid recipients and operates in Milwaukee County. Enrollment is voluntary. I-Care operates under sole source authority from HCFA while developing additional capacity to expand the program. Quality indicators specific to the SSI population in addition to relevant indicators used for Wisconsin Medicaid HMOs were developed in 1998. These indicators include ambulatory sensitive hospitalization rates.

- **Children's Mental Health Managed Care Programs.** Wisconsin has two Medicaid managed care programs for mental health services for children with severe emotional disturbance and at risk for out of home placement. The *Children Come First (CCF)* Program enrolls 119 children in Dane county. *Wraparound Milwaukee (WAM)* operates a similar program for 461 children in Milwaukee County. Primary health care and prescription drugs are paid fee-for-service. Both programs operate under sole-source authority from HCFA due to the specialized target population that can enroll. Program evaluation includes outcome, process, and structure indicators and external professional peer review.

- **The Health Maintenance Organization (HMO) Program.** The Wisconsin HMO Program was initiated in 1984 to provide Medicaid benefits to recipients of *Aid to Families with Dependent Children (AFDC)* throughout Wisconsin. In 1997, the HMO program was expanded statewide.

  In 1999, the *Badger Care Program* was initiated to provide health benefits to uninsured Wisconsin children and parents. In 2000, the Department contracted with 15 HMOs for the AFDC and Badger Care Program, serving 68 of 72 counties in Wisconsin. As of July 2000, there were 182,158 enrollees in the AFDC/Healthy Start managed care program, and 45,257 enrollees in Badger Care.

**The Wisconsin Partnership Program and Home Health Agencies**

Like PACE, the Partnership Program has some services that overlap with home health agencies' services, but a Partnership program is not a home health agency. They have different legal definitions. PACE and Partnership programs are alternatives to the home health benefit.

Partnership programs can provide or arrange for the provision of all Medicaid and Medicare services, including home care, but they provide much more extensive services and are evaluated and regulated differently.

The Wisconsin Partnership Program secured an exemption by Wisconsin Statute so that there is no requirement that it be licensed as a home health agency.

## LESSONS LEARNED

### The Integrated, Collaborative, Interdisciplinary Team Model

- The collaborative, interdisciplinary version of an integrated care model has proven to be a successful route to achieving the major goals articulated as the ideals of the program. It has resulted in an increase in people's ability to live in the community and participate in decisions about their own health care, and has improved the quality of health care and service delivery while containing costs.

- In response to questionnaires, the team approach has been unanimously deemed essential by everyone involved in the Wisconsin Partnership Program.

- Quality of care, utilization management, the integrity of model, and the success of the team are largely dependent on the establishment of a strong collaborative working relationship between the primary care physicians and the nurse practitioners.

- Participating team members report that all relationships, including the core relationship between the physician and the NP, improve and mature with time. Improved relationships result in coordination for better care and fewer hospitalizations. Regular communication between members of each team seems to improve the efficiency and satisfaction of team members.

- The Partnership organizations affirm that the key to their model is individualization of care and good resource allocation. Consequently, they do not expect to ever impose limits on how frequently members can see their primary physician.

- Team members report job satisfaction is high, and that influences the quality of service, which in turn reinforces job satisfaction. More than one program administrator has commented that the success of the teams and the team structure for the most part has been because the team members are "the best and the brightest." High job satisfaction acts as a magnet for the best and the brightest. It attracts people who can say, as one team member said, that they "truly enjoy diagnosing problems, finding solutions, especially when they aren't easy." The organizations themselves take on the risks involved in being a Partnership organization because they actually do care about the people they serve. Job satisfaction is their reward.

- By their own report, team relationships are cemented by a "shared commitment to quality." As one team member put it, "Joint knowledge allows empathy, sympathy, emotional support via sharing, exchange of information, strategies, and advice by team members. I am very committed to the program because of that, because of the team approach."

**Positive Outcomes of the Team Model**

- *Integration of service delivery.* When consumers are served by an integrated and interdisciplinary team, rather than by multiple providers, each individual is treated as a whole person rather than as a collection of broken parts, illnesses, and conditions. The team brings together various areas of expertise, and the collaboration between team members makes it possible to spot the relationship between a consumer's different needs – between the consumer's health, psychosocial, and daily living needs. This makes it much more likely that problems will be solved before they interact and create new complications. And it makes it much less likely that care will be fragmented, redundant, or discontinuous. The team makes decisions jointly, enhancing the information each discipline has about what the other disciplines know and do. The result is higher quality care.

  ✓ Where disciplines overlap in their expertise, collaborative decision-making minimizes duplication, the occurrence of multiple and divergent approaches to the same problem, and the possibility that each discipline could think the other was responsible for addressing the problem.

  ✓ Collaboration between team nurses and social workers has the greatest potential for producing insights, experience, professional connections, and knowledge about the continuum of settings in which consumers are found.

  ✓ Although not an official member of the Partnership team, the Team Coordinator – when added to a team – has alleviated some pressure from NPs and RNs day-to-day scheduling and administrative tasks. This in turn leads to increased patient contact. In addition, a Team Coordinator can improve the cost effectiveness of the program because their time is not as expensive as either NPs or RNs.

- *Integration of management.* When managers are responsible for the whole of a program rather than for separate "parts", they have a clearer overview of what improvements are needed, what resources are available, the benefits to the consumer, and the overall costs. The result is that management is more clearly in control of the best use of resources to achieve the goals of the program.

  ✓ Collaboration forces interdisciplinary discussions about how to prioritize the interventions selected and the resources used – this reduces conflicts where each discipline advocates using limited funds for the problems most relevant to their own area of focus.

- *Integration of finance.* When separate funding sources, programs and participating agencies are integrated, there is a single but collaborative sharing of responsibility. The financial managers at each participating organization have no motivation to shift costs. They are in control of the total costs and can more easily and more accurately identify unnecessary spending.

- ✓ Most team members felt the Wisconsin Partnership Program is cost effective, and many felt the system saves a great deal of money compared to the more traditional way of care.

- *Integration of Quality Control.* When all services are integrated, the quality assurance system can recognize the interrelationships between services and create a set of chosen standards to assure that both the individual "parts" of the system and the system as a whole are working fine.

- *Productive Flexibility.* In return for a fixed payment per person, the Wisconsin Partnership Program gets both more responsibility and more flexibility. The flexibility demonstrates its impact in several ways.

  - ✓ Teams in action are fluid in response to member needs. This has a snowballing effect on teams that have been together for awhile. Their interactions are less restrained because they know as a team they can get what is needed done. The size and composition of each team can also be responsive to case-specific needs.

  - ✓ Services can be much more comprehensive. For example, a physician's phone consultations can be paid for by the Partnership where they are not normally paid for by Medicare and Medicaid.

  - ✓ New local alliances can be readily formed. For example, Community Care for the Elderly in Milwaukee is collaborating with the Milwaukee Housing Authority, Milwaukee County Department on Aging, SET Ministry and others on a continuing care model for low income seniors who reside at a government subsidized housing complex in Milwaukee

**Challenges to a Successful Partnership Program**

1. *Reconciling Conflicting Perspectives*
   High quality, patient-centered care has many meanings depending on whether it is defined from the perspective of patients, families, nurses, social workers, regulators, or others. Wisconsin Partnership Program researchers discovered significant differences between nursing and social work professionals about the meaning of these concepts. The differences were most pronounced between health care providers with experience in acute care or skilled home care roles and social service providers located in community settings. It is important to reconcile the different meanings in order to arrive at both an operational definition and the appropriate strategies for implementing high quality, patient-centered care.

   In Wisconsin's Partnership Program, decisions about how to structure, supervise, house, recruit, and operate the team are guided by the assumption that discipline-related differences in perspectives are to be addressed and resolved.

| KEY LESSON LEARNED |
| --- |
| Health care providers need to view their recommendations in the larger context of the participant's life in general. Social service providers need to view the participant's general quality of life in relation to the health problems and related treatments. All team members have to learn to listen to and appreciate contributions from the other disciplines. They have to let go of the sense of primacy of their own discipline, and consider responsibility for the member's well being as shared, not solely one person's burden.<br><br>The nature of the conflict between the health care perspective and the social work perspective is very instructive. A fuller discussion of this conflict is included in the appendices. |

2. *Balancing Authority and Control*
   Initially in Wisconsin many social service staff members and team members from the wider community feared the consequences of shifting authority for the expenditure of long-term care funds from the social services network to one that combines health care and social services. They feared the shift could result in dominance by the health care providers, an over-medicalization of long term care, and a depletion of resources available for non-medical support.

   On the other hand, clinical staff felt the level of frailty and the complexity of health concerns required a close and consistent involvement of skilled health care providers.

| KEY LESSON LEARNED |
| --- |
| It is crucial to find common ground between disciplines and to develop a trusted balance of authority. |

3. *Management and Reporting*
   Managers from outside the team can influence a team member about differences within the team – even if it is just to commiserate about the dispute. Team managers need to encourage team members to return to the team for any needed conflict resolution.

| KEY LESSON LEARNED |
| --- |
| A single facilitator or supervisor for the team, rather than separate supervisors for each discipline, promotes more effective team functioning. However, this requires a very skilled, experienced person who does not promote divisions by supporting a particular philosophy or approach. |

4. *Preparing Community-based Organizations*
   Community-based organizations are responsible for establishing the capacity and infrastructure to provide integrated health and long-term care. To become successful as Partnership organizations, they must make the transition from a human services agency to a health and human services agency. They must master risk management, utilization review, quality assurance processes and committees, provider network contracting and relations, and the development and implementation of a successful on-call system. They must learn how to enroll and serve extremely complex cases.

5. *Risk Taking*
   Some Partnership organizations believe responsibility for risk has been a contributing factor to their pursuit of effective team functioning. However, high stress and fear of risk taking can promote a return to a more divided, less integrated team functioning. Conversely, the shared nature of risk taking by the team can result in a permissive or cautious tone that influences team decision-making. The team needs to be aware of this phenomenon so as to monitor the extremes.

| KEY LESSON LEARNED |
| --- |
| Shared accountability can contribute to a willingness to take those risks that promote member choice. This is possible when the risk decision is made and supported by the team rather than a single individual. |

6. *Members' Needs*
   In Wisconsin, the participating community organizations discovered that the population they were serving had significantly more complex medical and social issues than anticipated. Mental health, alcohol and drug abuse can be a challenge to the goal of responding to the needs of the whole person. The infrastructure needed to operate the program may require added expertise in acute and primary health care.

7. *Physicians' Perceptions*
   The physician community may need to be re-oriented to accept the concept of team problem-solving and may be reluctant to work with Medicaid patients. This will demand extra effort in recruitment and extra effort from the nurse practitioner to help the physician feel comfortable with the team approach. In Wisconsin, participating

physicians who responded to a questionnaire indicated growing acceptance and enthusiasm about the effectiveness of the team structure. However some Organizations report that physicians vary in their use of NPs and in their comfort level with NP care.

8. *The Physician Panel*

Each Partnership organization has put much thought and deliberation into the development of the physician panel. Although there are similarities among the organizations, panel development differed according to the geographic area served, target population, and urban area vs. rural area. Arriving at the right balance for both the benefit of the participant and for the effective operation of the team has proven to be difficult.

- ✓ The freedom to let members choose their primary physician remains a high priority for the organizations involved in the Wisconsin Partnership Program. However, some complications have arisen due to this priority. The number of physicians is growing very rapidly due to the high number of patient referrals. When a new patient joins, very often a new physician is brought into the program. This can be both good and bad. While it is rewarding to see new people become involved in the program, it becomes difficult to integrate them into the program quickly and efficiently. Utilization review and practice trends are difficult to interpret and manage with those physicians who have few members on their patient panel.

- ✓ As more physicians become involved in the program, it increases the number of people that RNs and NPs must try to keep in contact with. This makes communication quite time consuming. It also makes it harder for RNs, NPs and physicians to build the strong, trusting relationship that is necessary for optimal patient care. Some team members recommend that there be a limit to the number of physicians enrolled in each program.

- ✓ One urban Partnership organization reported that most of their participants seem to care less about the specific physician they see than about their ability to use the hospital of their choice. Many had little or no care prior to enrolling in the program. Few had a long-standing relationship with a physician. The difficult part of keeping available so many hospitals is setting up multiple contracts and managing the specialists.

9. *Predicting the Right Mix or Ratio of Providers to Members*
   Cost-effectiveness hinges on each team carrying a "full" caseload. However, the work associated with each member varies with complexity and acuity in both health and social domains. Members' needs vary from person to person and from time to time. Because of these contingencies, it is difficult to predict the right mix or ratio of providers to members. Wisconsin has not yet arrived at a solid conclusion about this mix. It would be useful to develop a tool for assessing member complexity and acuity to assist in predicting workload**.**

   - ✓ Some Partnership organizations believe the number of social workers needs to increase. Many times when the SW is not available, the NP or RN takes on the roles and responsibilities that the SW would normally handle, such as counseling tasks. In some cases, RNs spend time helping members with chores simply out of a misplaced sense of responsibility. Because the cost of an RN or NP is higher than an SW, this could impact the cost effectiveness of the program. Of course, an increase in SWs would also allow RNs and NPs to focus more of their time on health-related duties.

10. *New Team Members*
    Integrating the health and social service perspectives is hard enough for experienced providers from both psychosocial and health care disciplines. When a new provider is placed on a team, it can be overwhelming to the new person.

| KEY LESSON LEARNED |
| --- |
| New members need to be well oriented so they neither capitulate in order to fit in nor resist in order to defend their discipline's authority. |

11. *Preparing Guidelines*
    Some team members feel that their roles and the relationships among team members are not always clearly defined. Although many enjoy greater freedom within this system, some feel that in many instances there is a lack of designated protocol. While changes are sometimes recommended, almost all team members value the flexibility of current guidelines.

    - ✓ A set of guidelines that are not overly restrictive can still help to clearly define a team member's responsibilities.

    - ✓ A more formalized training and introduction to the program could also limit the number of questions and misconceptions after a new team member has joined.

    - ✓ Some Partnership organizations recommend developing nurse practice guidelines and care pathways to standardize care and reduce unnecessary variability in management. One organization developed "guidelines and pathways around" 20 conditions that were either problem prone, high risk, or high volume.

*12. The Team-Pharmacy Relationship*

Drug utilization and the relationship with pharmacies are areas that some Partnership Organizations feel need to be improved. Some suggested measures to improve the relationship are to develop a formulary to guide physician practice and a sophisticated utilization review process.

**A Last Word on Lessons Learned**

- ✓ From vision to reality, things change. It took a long time to operationalize the vision. Some things worked. Some things didn't.
- ✓ The prime project manager must be patient and persistent. Everything takes longer than expected and there are surprises around every corner.
- ✓ Specific measures can help community-based organizations learn health care.
- ✓ It takes years to build the desired data and quality systems to support integrated health and long term care programs. Start early and keep at it.
- ✓ Plan but also take risks, because when you do things you learn what works and what doesn't.
- ✓ Be flexible because there is more than one solution to every problem.
- ✓ Don't forget why you are doing this work – to improve the quality of life of very vulnerable people.

# PART II

## IMPLEMENTATION OF AN INTEGRATED CARE PARTNERSHIP

## ACTION PLAN FOR THE STATE

### A. Set These Actions in Motion as Soon as Possible

- Conduct a feasibility study to determine the potential market, how the service capacity can be developed to operate the program, and the financial requirements to develop and operate the program.

- Design and conduct focus groups to help develop a mission statement, operational protocols, a quality assurance system, and insight into member-focused organizations  It will also help you get member/consumer buy-in.

- Make early contact with the federal Health Care Financing Administration (HCFA) to begin the process of securing an 1115/222 Medicaid/Medicare waiver. The waiver allows your organizations to receive capitation payments from both Medicaid and Medicare.

- Contract with researchers to document and analyze the evolution of the program, specifically examining how to provide high quality, consumer-centered care through interdisciplinary teams.

- Write Protocol Manuals to describe organization operations for the community-based organizations, and to describe administrative operations for the staff who administer the contracts and assure the quality.

- Encourage community-based organizations to learn health care in order to prepare for being a Partnership organization.

### B. Work closely with HCFA

- HCFA showed real willingness to collaborate with the Wisconsin Department of Health and Family Services in the development of the Partnership Program. It is important to work closely with assigned project officers.  The project officers can be very helpful in navigating the federal bureaucracy.  However, be aware that federal budget constraints have limited staffing at HCFA, and project officers are at times overworked and not fully available.

- The project officer is of key importance in negotiations for obtaining the necessary waivers. Right from the beginning, be sure that pertinent staff establishes a regular schedule of meetings and calls.

## C. Secure the Dual Waiver

1. HCFA will make a organization visit, and this visit is of crucial importance. Refer to the Appendices for a checklist of what the Wisconsin Partnership Program found necessary to have in place in order to pass the organization visit and become operational.

2. Negotiations must cover:
   - *Medicare+Choice contracts between HCFA and the organizations* Wisconsin's Partnership waiver was written to respond to U.S.C. 1395. During negotiations, Medicare+Choice (M+C) became a reality and HCFA chose to contract with Partnership organizations as M+C entities. Medicare + Choice is a Medicare managed care option under which an organization is capitated to supply all Medicare services.

     It is essential to have consistency among M+C requirements, your waiver application, the terms and conditions of the waiver, and the protocols adopted through the waiver.

     NOTE: In the process of negotiating the Dual Waiver, you will also be negotiating the Medicaid and Medicare contracts and your capitation methodology.

   - *Reporting of budget neutrality to HCFA*

     Under the 1115/222 waiver, the program must be budget neutral, i.e., in the case of the Partnership Program, an organization may not increase the average per person per month Medicaid cost beyond what is paid for those served in PACE, nursing homes, and home and community-based waiver programs.

     How the budget neutrality will be determined and reported must be negotiated with HCFA. Wisconsin's negotiations with HCFA over the reporting requirements were not resolved until a year after the waiver became operational.

   - *Creation of complaint, grievance and appeal processes* that incorporate both Medicare and Medicaid principles and are clear to consumers. Creation of this system was a joint activity of the state and the Partnership organizations. (See Appendices for more details).

3. Address Medicare and Medicaid disconnects. With a dual capitation and service for dual eligibles, the additional challenge to a Partnership Program is to define as clearly as possible and translate into practical application the connects and disconnects between Medicare and Medicaid. The silo character of the two programs, and the ensuing cost shifting between them, is highly recognized. The problem for dual eligibles is the undefined land, the disconnects, in which the

programs do not speak to one another. A prime example of a disconnect is the difference in the prescribed dates for member enrollment and disenrollment. Resolving a problem such as this calls for an in-depth working knowledge of both Medicaid and Medicare regulations. It also calls for creativity and persistence in working with the regulations to make the resolution of the disconnect transparent to the participant.

4. Work diligently to supply accurate and timely enrollment, utilization, and evaluation data.

## D. Assist in Creating and Maintaining Interdisciplinary Teams

At the start, team members need to have a thorough understanding of their own profession, how their discipline-specific priorities affect the way they provide care, and how these different approaches to practice can be integrated for the benefit of the members they serve.

In response to commentary from the Partnership Organizations, the Wisconsin Department of Health and Family Services in coordination with the University of Wisconsin research team developed a curriculum workshop devoted primarily to achieving the kinds of relationships that are fundamental to effective team operations. The workshop helps team members discuss and explore how to provide collaborative, consumer-centered care in integrated care settings.

*The objectives of the curriculum are to:*

- Assist providers in understanding their work as a representative of a particular professional discipline;
- Provide opportunities to share discipline-specific knowledge with colleagues in the same or other disciplines;
- Explore how different professionals define, provide, and evaluate consumer-centered care;
- Increase awareness about the values and expertise that members have, and how to integrate that expertise into team decision-making.

KEY FEATURE: In creating a team-building curriculum, keep your eye on the desired outcome. Each decision, plan of care, and individual member service plan should reflect the combined expertise of team members, including the member being served.

## ACTION PLAN FOR COMBINED STATE AND ORGANIZATION OPERATIONS

### A. Set These Actions in Motion as Soon as Possible

- Do research through state statutes to determine how the statutes might impact program development and operations. Make early contact with the Office of the Commissioner of Insurance in order to secure a waiver of licensure, or exemption order, and to operate a risk-based capitated program. The negotiations may be lengthy. This waiver is of crucial importance. Without it, risk reserve requirements of the Commissioner's Office would compel each Partnership organization to be licensed as an HMO.

- Begin thinking early about purchasing or developing an information technology system (ITS) for the program. The system should facilitate care management and service delivery, serve as a medical record keeper, capture a range of data, assist in resource allocation decision-making, and be able to create utilization reports. Wisconsin did not find such a system available for purchase and the Partnership Organizations collaborated to develop an ITS.

### B. Determine and Develop the Organizational Capacity of Contractors

*The State should require that Partnership Organizations provide both the State and HCFA with adequate assurances that they*:

- Have the capacity to serve the expected enrollment in the service area;

- Offer an appropriate range of services plus access to preventive and primary care services;

- Maintain a sufficient number, mix, and geographic distribution of service providers.

*To help determine organizational capacity:*

- The State should design and conduct feasibility studies.

- The Partnership organizations should analyze current capacity in terms of mission, philosophy, management, staff, physical environment, technology, and the financial capacity to establish adequate risk reserves.

## C. Establish Systems of Enrollment and Disenrollment

*Assess before enrolling*

- Assign specific roles in the assessment procedure.
- Conduct individual assessments in-home.
- Assess for functional and financial eligibility under the state Medicaid plan or your Partnership program waiver.
- Assess to identify issues, needs, strengths, and resources of each potential member – and other areas relevant to the elderly and to people with disabilities.
- Assess for which care or service the family and/or support systems can provide.
- Set a time limit for completing the assessment.

*Enrollment - Good intake is of key importance*
The following are some recommended steps:

- Provide program information to the potential member.
  - ✓ Include clear, complete and accurate information regarding the nature of membership in a Partnership program as compared to fee-for-service, including information on voluntary enrollment and prior authorization requirements.
  - ✓ Be sure the potential member understands the "lock-in" – while enrolled in the program, members must receive all covered health and long term care services directly from or through the Partnership organization or from sources that the organization has authorized.
- Know your services.
- Identify the member's primary care physician.
- Obtain member or guardian sign off on the initial plan of care.
- Implement a Personal Care Worker/Daily Living Assistant plan.
- Once the prospective member has met functional and financial eligibility requirements and agrees to enroll, he or she should fill out pre-prepared enrollment forms. (Note: Wisconsin uses an Enrollment Request form, a Program Enrollment form, and Partnership Enrollment Agreement).

*Disenrollment*

- Establish guidelines for voluntary and involuntary disenrollment.
- Create a Disenrollment Request form.
- Notify the member of the disenrollment date.
- Provide all needed services until the disenrollment date when capitation payment ends.

- Prepare a list of all those who would need notification – such as, the Medicaid fiscal intermediary, the Medicare enrollment agency, the Partnership program manager and team members, etc.

## D. Develop Management Information and Utilization Systems

As stated earlier, you will need to purchase or develop a management information system as well as systems for processing all aspects of service delivery and utilization.

*Management Information System (MIS)*

- The MIS should maintain the consistency of the team process for determining allocation of services.
- The MIS should collect data and maintain records.
- The MIS should be capable of producing periodic reports on all of the following:
  - ✓ Encounter data;
  - ✓ Financial information;
  - ✓ Quarterly narratives;
  - ✓ Complaints, grievances and appeals;
  - ✓ Third party liability;
  - ✓ Federally qualified health centers;
  - ✓ AIDS and ventilator dependent members;
  - ✓ Sterilizations and hysterectomies;
  - ✓ Insurance Commission;
  - ✓ Personal injury statements.

*Utilization Management System*

Organizations will need to prepare a Utilization Management Plan that describes how the organization will identify over- and under-utilization, develop trend data and benchmarks, and utilize consumer feedback.

Utilization Management should include:

- Prior authorizations;
- Concurrent review requirements, such as hospitalization and routine services;
- Retrospective reviews to assess:
  - ✓ Accuracy of prospective review information;
  - ✓ Effectiveness of screening and risk assessment;
  - ✓ Necessity and quality of services provided;
  - ✓ Validity of review determinations and authorizations;
  - ✓ Potential areas for future prospective and concurrent reviews;
  - ✓ Modifications to clinical and administrative policies or protocols.

*Retrospective reviews should pay particular attention to:*

- Invasive medical procedures;
- Premature hospital discharges;
- Emergency services;
- Preventable admissions, incidents, illnesses or injuries;
- Quality and reliability of delivered services;
- Hospital admissions among nursing home residents.

## E. Design Evaluation, Quality Assurance and Quality Improvement Program

The goal of the Quality Improvement Program (QA/QI) is to protect, maintain and improve the quality of care provided to members.

The Wisconsin Partnership Program engaged the University of Wisconsin-Madison to document and research implementation experiences and consumer responses, and to develop and test quality assurance protocols and quality indicators based on the expressed values of consumers.

Consumer-defined quality indicators have been integrated into Partnership organizations' internal quality assurance systems. The research team also developed a set of model quality improvement studies currently being used at each organization. These studies are being used to develop and refine quality indicator outcome measures.

The research team also developed evaluation survey questions for Partnership members based on the model QI study areas. The questions were developed specifically to provide members an opportunity to evaluate services and provide feedback to Partnership staff about the quality of care in service areas that consumers identified as indicative of high quality care.

*The QA/QI Program should include the following elements:*

- A coordinator responsible for the operation and success of the program;
- A committee of both medical and psychosocial professionals to implement all aspects of the program;
- Personnel sufficient to meet the goals of the program;
- An annual plan. Determine early what studies and standards will be included in your plan for both elderly members and members with disabilities. Be sure to include member satisfaction studies.

*Some Recommended Procedures:*

- Conduct interviews and observations of management, the clinical team, members, and members' families to identify service quality standards. Demonstrate those quality standards in program implementation and oversight.

- Carefully research and document implementation experiences and consumer responses.

- Develop and test quality assurance protocols and quality indicators based on the expressed values of consumers.

- Establish annual quality goals based on information from Utilization Management, Member Health, Risk Management, Complaints and Grievances, and Quality Improvement studies.

- Require the cooperation and participation of providers and subcontractors.

- Develop or adapt practice guidelines and standards of care to assure quality service among direct care and contracted providers.

- Monitor corrective actions until the problems are solved.

- Oversee quality of life indicators.

*Audits*

HCFA and/or the State Medicaid Agency has the authority to inspect and/or audit your Partnership Organizations or their subcontractors during the life of the contract and for five years after. Audits may be conducted in the following contract-related areas:

- Financial;
- Medical (documentation and records);
- Program (utilization, enrollment, services, grievances, subcontracts, and memorandums of understanding);
- Others as determined by HCFA and your state regulating agency.

**Note: Partnership organizations have the right to review and comment on any studies or audits that are going to be released to the public.**

## F. Work with Hospice

The Partnership program respect members' wishes for hospice-related services.

- **For those who have dual Medicare and Medicaid eligibility**:
  When they are eligible and wish to receive Hospice services from a Medicare Hospice program, the member must disenroll from the Partnership program and

enroll in a Hospice program. The Partnership organizations facilitate the transition to a Medicaid fee-for-service and a Medicare Hospice program.

If the member wishes to receive their Medicaid services through the Partnership Program, the Partnership Organization must have a signed memo of understanding with the Hospice organization. The memo must identify such issues as how care will be coordinated, prior authorization, team decision-making, and the prevention of cost shifting. The memo must be reviewed and approved by the state and the HCFA project officer.

- **For those who are eligible for Medicaid only**:
  When they are eligible and wish to receive Hospice services in a Hospice program, the member may disenroll from the Partnership program and enroll in a Hospice program. The Partnership organizations facilitate the process.

  If a member wishes to receive his or her Medicaid services through the Partnership Program, then the same process noted above for the dual eligible members applies (getting a signed memo of understanding).

## ACTION PLAN FOR PARTNERSHIP ORGANIZATIONS

### A. Set These Actions in Motion as Soon as Possible

- Develop a system for obtaining appropriate levels of care determinations for your participants. Differences between raters cause inconsistencies. The differences between institutional and community care have a fiscal impact on the program.

- If your program seeks to build a physician panel from primary care physicians brought to the program by members wishing to enroll – as well as from efforts to recruit – you may need to re-evaluate your policies as the size of the panel grows.

- Create a system for the sharing of all documentation to reduce fragmentation and redundancy of care.

- Be prepared to fine-tune the interdisciplinary team, both in terms of the number of members a team can effectively serve and the number of professionals within the team.

- Make efforts to learn about health care.

  - ✓ Put people on the board of directors who have strategic expertise in marketing, fiscal matters, human resources, and clinical matters.

  - ✓ Put a strong management team in place *before* the organization can afford it – these managers can establish the systems and prepare plans so you *can* afford it.

### B. Define the Goals, Responsibilities and Roles of the Interdisciplinary Team (See Appendices for More Details)

*Primary Goals of the Team*

- Integrate health care and social services practically and conceptually.

- Take responsibility for the care of participants across multiple settings.

- Build consumer perspectives into the creation, evolution and evaluation of team functioning.

*Primary Responsibilities of the Team*

- Provide service coordination.

- Designate a facilitator for conflict resolution, and to ensure timely decision-making and follow-up.

- Ensure that member goals and preferences are identified, documented in the service plan, and addressed.

- Provide in-home assessment of safety issues and work with members to manage risk.

- Provide information and support to the member in making choices within the parameters of your organization.

- Develop, monitor and review the service plan with the member.

- Facilitate the exercise of the member rights and responsibilities.

- Develop relationships aimed at joint, shared responsibility in developing the service plan and providing needed services as decided by the team.

NOTE: As indicated earlier, developing relationships between team members can take time since definitions of quality care and patient-centered care vary by discipline. Plan time for developing team relationships.

- Provide education to members and families regarding health and social needs.

- Identify each member's informal support systems/networks in relationship to his or her functional and safety needs.

- Report information to team members and appropriate health care providers as needed.

- Assess and assist members in quality of life issues.

- Meet documentation and reporting requirements in a timely and accurate manner.

- Provide links/coordination with care provided across settings.

- Maintain contact with the member during hospitalization or nursing home admission.

- As appropriate, represent the member's point of view when the member is unable to participate in decisions.

*Member/Team Shared Responsibility*
The team and the member will jointly identify health and social services that are essential to the member's mental and physical health and safety plus services that are necessary to support the member in the context of his or her own resources, capabilities and goals for work and participation in the community. Be aware that the

degree to which members wish to participate may vary from person to person and over time.

*Member Rights and Responsibilities*
Prepare a Rights and Responsibilities document for members. Be sure to acknowledge the parameters of a member's participation in all decision-making and his or her responsibility in complying with those decisions.

*Roles and Functions of Team Members*
The Medical Director oversees the systems that assure the quality and cost effectiveness of medical care. The Medical Director also helps to resolve difficult medical decisions, especially when the interdisciplinary team fails to reach consensus.

Primary Physicians (See *Recruitment*, Section C. to follow.)

The Nurse Practitioner (NP) forms a collaborative practice arrangement with the physician, and performs the following duties:

- Augments the primary care provided by the physician;
- Provides initial history and physical exam;
- Provides periodic re-evaluation of medical status;
- Provides evaluation of episodic illness in the member's residence or in an office/clinic setting;
- Ensures that health maintenance standards are offered and accessible;
- Assumes the leadership role in collaborating with appropriate providers prior to, during, and at discharge from inpatient settings, sub-acute care settings, and short-term skilled nursing homes, and nursing homes;
- Orders diagnostic or therapeutic interventions;
- Serves as primary liaison between the team, the member, and the primary care physician.

Registered Nurse (RN)

- Assesses physical and health status, response to illness and to medication.
- Provides in-home assessment to identify functional limitations and adaptations to his or her environment.
- Provides skilled nursing services to members.
- In conjunction with the nurse practitioner, provides prevention and health maintenance education to members.
- Assesses the need for and coordinate supportive home care services provided to members.
- Delegates appropriate aspects of member care to the Daily Living Assistant or Personal Care Worker (DLA/PCW); also supervise and evaluate the effectiveness of the care given.
- Ensures that the DLA/PCW written plan is reflective of member needs, is current, and provides sufficient direction.

Social Worker (SW)/Social Services Coordinator

- Provides psycho-social/economic assessment.
- Explores financial options and eligibility, including employment services.
- Provides information and assist member in housing issues.
- Provides information and assist member in maintaining and establishing community links.
- Provides on-going coordination of psycho-social services.
- Assists in crisis intervention.
- Provides assessment and coordination of mental health, alcohol or drug abuse services.

Personal Care Worker/Daily Living Assistant (PCW/DLA)

- The PCW/DLA should be capable of performing basic and/or advanced skills prior to assignment.
- Advanced skills are performed as delegated by the team's Registered Nurse.
- Both basic and advanced skill activities must be performed according to a written PCW/DLA plan that includes the member's preferences and the interdisciplinary team's input.
- The RN should make sure the PCW/DLA plan is understood by the team, including the participating member and updated as the member's needs change.
- The PCW/DLA plan should detail both basic skills and the parameters of the advanced skills.

## C. Recruit the Physician Panel and Primary Care Providers for the Team (See Appendices for More Details)

*Preparatory Tasks*

- Identify and recruit your Program Director and Medical Director.
- Build credibility with the medical community and stakeholders.
- Create a Physician Provider Manual detailing the complete roster of duties and team expectations. Be sure all primary care physicians receive the manual.

*Recruitment*

Wisconsin Partnership organizations found three complementary approaches to initiate partnership relationships with primary care physicians:

1. Recruit members who bring their primary care physician into a relationship with your Partnership program. This approach has the advantage of being direct, efficiently targeted and member-centered. However, since many physicians are a part of an HMO or a provider network, you will need to build relationships and arrange appropriate contracts with many different HMOs and networks. This is time consuming and makes it necessary to pursue multiple approaches to recruitment.

Wisconsin Partnership organizations suggest follow-up calls, visits or direct mail to physicians who come into your organization through members. You will need to be sure they get your Physician Provider Manual and that they are willing to abide by Partnership protocols.

2. Partnership organizations also contract with hospital networks and possibly with HMOs for essential acute care services. This provides immediate access to a substantial number of physicians, including primary care physicians.

   Each Partnership organization also develops a recruitment strategy. Here are some strategies suggested by Wisconsin Partnership organizations:

   - Look to the needs of the community you serve. For example work with the hospitals or physician groups that have a strong presence in the areas of the city where you do not already have a strong presence.
   - Check with physician groups who refer a large number of persons to your program and see if they have a desire to serve your population and if they meet your criteria.
   - Once you are up and running you may find that providers – including physicians, hospitals, or non-profit groups – will come to you with a desire to join.

3. Physicians and HMOs provide referrals, and contacts are also developed from marketing activities at seminars, from written materials, and from individual physician meetings. In some cases the Medical Director has a network of contacts who could offer referrals.

*Recruitment Qualifications*

1. Determine your physician recruitment strategy and contract with physicians who agree with:
   - Your Partnership Program philosophy;
   - Collaboration with a nurse practitioner;
   - Participation in an interdisciplinary team;
   - Working collaboratively with your Partnership Organizations Medical Director;
   - Participating in utilization management and quality improvement processes.

2. Physicians you contract with must be:
   - Qualified to participate in Medicaid and Medicare programs;
   - Board certified or eligible in their specialty, or otherwise verified as competent;
   - Clearly reputable.

3. Only contract with physicians on a fee-for-service basis. While subcapitation may be discussed, it will require prior review and approval by the state and HCFA.

*Physician Panel Growth*
There cannot be unrestricted growth of the physician panel. You will want to look for ways to strike a balance between the size of enrollment and the physician panel.

Some suggested strategies to achieve this are:

- Secure the physician's commitments to serve a minimum number of participants;
- Recruit whole clinics at one time, gaining efficiencies in time management and physician orientation;
- Remove physicians from the panel who do not demonstrate "buy-in" to the Partnership model.

**D. Prepare Provider Subcontracts**

*Physician Contracts*
Partnership organizations have a signed contract with physicians or physician organizations that specifies the requirements for physician practice within their Partnership Program. Contracts include:

- Provision for discharge should the physicians fail to adhere to elements defined in your Physician Provider Manual;
- Minimum standards for physician credential verification;
- The scope of physician services;
- A defined relationship with the Partnership Organization's Medical Director;
- Prior authorization requirements;
- Standards for waiting and response times for routine, urgent, and emergent client visits, and for 24-hour service coverage;
- Standards for physical accessibility;
- Standards for back-up and on-call procedures;
- Terms of physician fee-for-service compensation arrangements;
- Malpractice insurance requirements;
- A statement of independence and non-indemnification;

- A requirement for participation in quality, utilization management, and peer review;
- A requirement for collaboration with the nurse practitioner and interdisciplinary team;
- A requirement to maintain medical records.

*Customizing the Contract*
The description provided above is not be exhaustive. Other provisions that might be included are:

- Member-developed standards for physician interaction with members;
- Requirements for participation in various meetings;
- Standards for participation in continuing education;
- Other items as specified by the individual contractor that are not in conflict with required elements.

NOTE: Wisconsin Partnership Program found it useful to create and have signed collaborative practice agreements between physicians and nurse practitioners. These agreements define both the physician's and the nurse practitioner's roles and the working relationship between them.

**E. Design the Financial Management Structure (See Appendices for More Details)**

*Some Necessary Steps*

- Evaluate the range of services to be provided;
- Identify the support available in the provider community, including state and local public agencies, advocacy groups, consumers, providers, and managed care organizations;
- Identify existing funds and structures for the development of purchasing specifications and delivery system contracts to create a value-based and cost-effective care system;
- Account for current resources, evaluate what is available and what additional resources are necessary;
- Determine benefits to be covered;
- Identify where Medicaid benefits end and where other systems of care – such as Medicare or other state and local funding sources – can begin to assure coverage across the continuum of care;
- Determine what to contract for to meet the contracted benefit package – or what is included in a full-risk contract;

- Understand Medicaid and Medicare reimbursement requirements;
- Develop an in-depth understanding of risk sharing;
- Take the necessary steps to establish a risk reserve;
- Develop a rate capitation method.

*Some Cautions Concerning the Capitation Rate*

1. A Partnership Program operates in a managed care environment and requires a capitation reimbursement mechanism for acute and primary long-term care services.

2. The Federal Government requires the rates to be computed on an actuarially sound basis.

3. Medicaid capitation cannot exceed the Upper Payment Limit restrictions imposed by Federal regulation on Medicaid managed care programs. (The managed care organization cannot exceed the cost of delivering the same set of services to a comparable population in a fee-for-service environment.)

4. The methodology needs to assure adequate payments for the targeted population. The rates need to reflect that the use of resources for the elderly and people with disabilities differs from the general population. Providers should not be at undue risk for caring for the population.

## F. Create a Service Delivery Plan

The Partnership team develops a written, individualized plan with each member that clearly identifies member preferences, goals, specified treatments and strategies, and the responsible person or provider. *A comprehensive service delivery plan emphasizes member's choice, communication, prevention, continuity and quality.*

- Include the member and family in the plan development and review – to the extent the member chooses. The desired outcome is to give the member the opportunity for input, to assure that the member understands the service plan as well as what can be provided and what is expected of him or her.

- Service coverage should provide or arrange for all Medicaid and Medicare covered services, including nursing facility, primary, acute, and long term support services.

- The interdisciplinary team implements, monitors and coordinates the service plan by providing service directly and overseeing and coordinating the delivery of services by contract providers.

- The team should coordinate smooth transitions and assure continuation and oversight of the service plan in all settings where the member may reside or receive care.

- Each team member should conduct an individual assessment in the member's residence that includes identification of the member's issues, needs, strengths and resources.

- The team will incorporate input from the Personal Care Worker/Daily Living Assistant into the plan.

- Services must be accessible to members in terms of timeliness, amount, duration and scope.

- Services must be provided by Medicaid and Medicare certified providers.

- Services must be available 24 hours a day, seven days a week. That includes emergency and urgent care services.

- The individual member should have one phone number to call with problems 24 hours a day. The organization must have a system in place to respond to member calls within an hour.

- The team should monitor the member's health and psychosocial status as well as the effectiveness of the service plan.

- If the member resides in a congregate living arrangement, the team should monitor the provider through observation, review of the provider documentation, and member/family feedback.

- The team should ensure that all relevant information is available to providers at the point of service.

- Health and psychosocial risk status should be monitored and assessed to trigger early interventions.

- The interdisciplinary team should meet at least weekly to review member issues, and should conduct formal service plan reviews every six months.

**G. Create a complaint, grievance and appeal processes (See Appendices for More Details)**

- Partnership organizations establish and maintain procedures for the fair and prompt adjudication of informal and written complaints, grievances and appeals raised or filed by members and/or their families.

- The plan is a careful melding of Medicaid and Medicare terms and requirements.